

Name: _____ Date of Birth: ____/____/____ Age: _____
 Last First MI.

Reason for visit:

- Routine Preventive Yearly Exam
- Referral Primary Care Provider: _____
- Problem (describe) _____

MEDICARE ONLY:

- Preventative Yearly exam with Pap/Pelvic/Breast exams
- Pap/Pelvic/Breast Exams ONLY

Gynecologic Information:

- No Periods
- 1st Day of last period: _____
- Periods are: Regular Irregular
- # of days of bleeding: _____
- Number of days from 1st day of one period to the 1st day of the next period: _____
- Contraception: _____ Not sexually active
- Do you have:

Yes No

- Cramping Mild Moderate Severe
- Abnormally heavy bleeding
- Bleeding between periods
- PMS Anxiety Depression
- Lack of control Moodiness
- Bleeding with or after intercourse
- Pain with or after intercourse
- Sexual difficulty - Other
- Infertility problems
- Abnormal discharge
- Hot flashes
- Night sweats

Health History Update

Since your last visit, have you had any NEW medical problems, new surgeries or hospitalizations? (Include year)

None No Change

Medications

Include any non-prescription drugs, vitamins, supplements, and birth control pills, as well as frequency and dose.

None

Current Pharmacy: _____

Location: _____

Allergies

(List the drug and the reaction you had) None

Social History

- Marital Status: Single Married Separated Divorced Widowed Live with partner
- Language: _____
- Religion: _____
- Education Completed: Grade H.S. Voc. College Advanced Degree Other: _____
- Employment Status: Working Occupation: _____ Unemployed Retired Disabled

Family History: (List the family member and the age diagnosed) No changes

- | | | |
|---------------------|----------------------------------|-----------------------|
| Alcoholism _____ | Hay Fever _____ | Obesity _____ |
| Asthma _____ | Heart Disease _____ | Osteoporosis _____ |
| Breast Cancer _____ | High Blood Pressure _____ | Ovarian Cancer _____ |
| Colon Cancer _____ | High Cholesterol _____ | Prostate Cancer _____ |
| Diabetes _____ | Mental Illness (list type) _____ | Stroke _____ |
| Glaucoma _____ | Migraine _____ | TB _____ |

Risk Factors No changes

- Tobacco: Never
- Year started: _____ Year Quit: _____
- Cigarettes: _____ packs/day Cigars: _____ #/week
- Chew: _____ cans/day Pipe
- Passive smoke exposure: Current Past

- Alcohol: No Yes
- Type _____ # Drinks _____ /day
- Caffeine: No Yes Drinks/day _____
- Exercise Type: _____ Times _____ /week
- Drugs: No Yes Type _____

SIGNATURE: _____

Review of Systems

Name: _____ DOB: _____ Date: _____

Problems you had in the past or are currently experiencing:

None

Past Present

General

- Weight Loss
- Weight Gain
- Fevers
- Fatigue
- Sleep problems

Breast

- Pain
- Mass
- Nipple Discharge

Kidney/Bladder

- Painful urination
- Leakage / incontinence
- Frequency
- Urgency
- Blood in urine

Cardiovascular

- Chest pain or tightness
- Palpitations or heart racing
- Difficulty breathing
- Shortness of breath with exertion
- Hand / ankle swelling

Respiratory

- Wheezing
- Coughing
- Shortness of breath
- Coughing blood

Gastrointestinal

- Bleeding from the bowels
- Indigestion / heartburn
- Gas / bloating
- Diarrhea
- Constipation
- Hemorrhoids
- Difficulty controlling bowel movements
- Abdominal pain
- Nausea / vomiting

Endocrine

- Hot/Cold intolerance
- Hair loss
- Hot flashes

Past Present

Musculoskeletal

- Muscle or Joint Pain
- Muscle weakness
- Fractures
- Loss of Height

Skin Problems or Cancerous Growths

- Skin Ulcers
- Moles
- Rashes

Neurological

- Headaches
- Numbness
- Seizures
- Trouble walking

Mental Health

- Depression
- Anxiety
- Forgetfulness
- Job problems
- Personal problems

Eyes / Ears

- Vision changes
- Wear glasses or contacts
- Hearing Loss
- Sinusitis

Allergy

- Persistent infections
- Hives
- Seasonal Allergies

Blood

- History of blood clots in legs or lungs
- Easily Bruised
- Excessive Bleeding

Signature _____



NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

SOUND
WOMEN'S
CARE

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

Where would you prefer we contact you with **CONFIDENTIAL** information regarding your treatment or test results? Please leave at least one number where we could leave you a message.

Home Yes _____ Number: _____ **Voicemail okay?**
Yes _____ No _____
No _____

OR

Work Yes _____ Number: _____ **Voicemail okay?**
Yes _____ No _____
No _____

OR

Cell Yes _____ Number: _____ **Voicemail okay?**
Yes _____ No _____
No _____

I give permission for medical information about me to be shared with the following:

_____ (Signature of Patient)

By my signature below, I acknowledge receipt of the Notice of Privacy Practices and give my permission regarding a confidential voice message as stated above.

I also hereby authorize my insurance benefits to be paid directly to Sound Women's Care, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers for payment of claims. I also authorize the release of information I request to be sent to insurance companies or employers (including disability forms).

PRINT NAME

Date of Birth

Patient or legally authorized individual signature

Today's Date

Printed name if signed on behalf of the patient
representative)

Relationship
(parent, legal guardian, personal)

This form will be retained in your medical record.